Problems of Homosexuality

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• **Moral, religious and legal attitudes in attempts to control sexual behavior have interfered with a clear view of the medical and psychological aspects of homosexuality. This phenomenon is probably much less destructive of social aspects of our society and culture than is generally believed, since it is actually more widespread than is generally acknowledged.**

Homosexuality probably has hormonal and undoubtedly social and psychological factors, the latter of which are the only ones which can be worked with successfully in our present state of knowledge. A general practitioner's task is to aid those who wish and need help with this problem in finding psychiatric treatment in the same way that persons with any other emotional disturbance are referred. This should be carried out without bias just as with any other emotional disturbance.

HARDLY ANY MEDICAL SUBJECT is more ambiguous and confused than that of homosexuality, and it is a most difficult subject for the clinician to delineate in a scientific or even empirical way. For centuries homosexuality has been more a moral and legal than a medical concern. Throughout the ages people have tried to make criminal law enforce their ambitions regarding moral law, especially in their attempts to control sexual behavior. Among sex laws, none are so punitive or inequitable as those concerning homosexual acts, particularly male homosexual activities.

Religious traditions and attitudes against homosexuality have thus been extended into substantive law out of all proportion to the social damage involved in most homosexual acts. Sin is confused with crime, and vague laws about sexual behavior give law enforcement officers a dangerous discretionary power. Sexual acts are not differentiated from criminal acts. Of course there are sexual acts that harm others and against which society must protect itself. But these are not clearly differentiated from sexual behavior that merely "tends to affront certain people"; and men are imprisoned for acts that did no damage to another person.

The great majority of homosexual acts do not endanger the social structure or disrupt the family. No doubt many early societies considered homosexual activity a threat to family and societal solidarity, and taboos arose; but when these are examined they can be seen as part and parcel of man's fears of his own impulses—drives for which he sought controls. Modern studies like those of the late Dr. Kinsey and his associates serve to show that society has little to fear from homosexual activity. Yet the fear remains, in that a homosexual person continues to be the object of extraordinary punishment or the butt of derisive jokes and contempt. We should remember, when we participate in such attacks, that we follow the age-old formula of trying to fight off or laugh off something that we either do not understand or fear. This extension of old taboos into moralistic and legal attitudes still muddles the issue of what is essentially a biological and psychological phenomenon and only secondarily a social one.

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THE EXTENT OF HOMOSEXUALITY

The problem of homosexuality is even more extensive than the Kinsey data showed. According to Kinsey, about a third of white males between adolescence and old age have had some type of homosexual contact to the point of orgasm, but only four or five per cent are exclusively homosexual. A much smaller proportion of females at any age are primarily or wholly homosexual; and very few continue their homosexual activities as long as do men. Men are likely to be far more promiscuous than are women; only about half restrict their relationship to a single partner or two, as compared to three-fourths of the women. These and other Kinsey data point to a greater extent of homosexuality than is commonly believed.

CLINICAL VIEW OF HOMOSEXUALITY

The Kinsey studies reported the amount of homosexual behavior in various persons, but did not determine clinically who was a homosexual. Are all 37 per cent of males who have had at least one homosexual contact homosexuals—or just the 4 per cent who have only homosexual outlets? If we define a group midway between these extremes as homosexual, we ignore the fact of a gradation of sexual activity, interest and preoccupation that ranges from one to the other extreme. We overlook the historical and developmental approach that de-

notes both biological and psychological roots for homosexuality.

The biological roots are clear: A phase in our ontogenetic development when the undifferentiated organism has the potential of developing into either sex. Psychologically, too, we receive tenderness, affection, abuse and cruelty at the hands of both men and women. So many factors in the history of each person shape his sexual destinies that to make the cause of homosexuality a simple one is not to face the facts.

Some observers believe that homosexuality is merely a matter of constitution and biochemistry, although present knowledge shows no basic difference in either constitution or biochemistry between the homosexual and the heterosexual. One should therefore strongly suspect claims about a cure of homosexuality by hormonal treatment. A British report on recent developments in psychoendocrinology stated that homosexuals cannot be changed to a more masculine attitude. "In most of them," the report said, "testosterone merely accentuates the homosexuality. In general, its action is to increase the quantity of the sex drive without in any way altering its main direction." Far more evidence indicates that environmental and developmental factors help to shape the individual's avenues of sexual outlet. But research in the whole area has only begun to tackle the problem of cause.

A story of my clinical experience in southern California some years ago will illustrate the complications involved in the evaluation of hormonal treatment. The medical literature at that time contained favorable reports of treatment of homosexuality by androgens, and it acquired a certain vogue. Several California jurists who knew the futility of sentencing homosexuals to jail began sentencing the convicted person to undergo treatment. Some persons were sentenced to have hormonal treatment, others to have psychiatric treatment. As a result of these efforts further articles reported successful treatment with androgens—successes that I as a psychiatrist envied.

One day a young man came to my office to consult me about a problem that only skirted on his homosexuality. A confirmed homosexual, he had little anxiety about his activities because he considered himself a constitutional homosexual and felt relatively blameless. In the exploratory course of our discussion he said that he had once been treated by androgens, not entirely of his own will, as the result of a court sentence. He then described how he and several of his associates had contrived to "respond" to the treatment, varying their stories so as to give them the hue of veracity. He said that he arrived late for his first appointment and grumbled at the injection. The nurse reminded him to return for his next one "or else." Next time he complained of noticing no improvement at all. On the third visit he told the nurse he was depressed and said that he and his boy friend had fallen out and might separate. Next time he was more depressed and was moving out, he said, because he could not tolerate his boy friend. The fifth time he carefully implied he was less depressed, and reported no difference except that he had no desire for anything or anybody. On the sixth visit he told the nurse: "A simply fantastic thing happened. I've been going to a local bookstore for years and never noticed before a very pretty girl who works as a clerk there." By the seventh visit he reported making a date with the girl and at the end of treatment he claimed satisfactory sexual relations with her. This case figured in a published report of successful treatment. Meantime this patient and his companions who had also been treated went on with their homosexual activities, except that some of them suffered from an increased drive—the result of the injections of androgens. How much of the exacerbation was biochemical and how much psychological, no one knows. Nor does anyone know to what extent similar ruses may have distorted medical results reported in the literature.

In the etiology of homosexuality, constitutional and hereditary factors cannot be ruled out as possible factors. From a pragmatic view, a large amount of evidence points to developmental factors, chiefly those connected with masculine or feminine identifications, as probably the most important ones. There are multiple reasons why a young boy might fear to identify himself with what he considered masculine trends and so be forced to adopt feminine attitudes, habits and wishes. In our society a happy male child evidently goes through various stages of identifications and choices of the object of his affections. At first he prefers himself, then he is greatly attached to his mother. In later childhood, under the molding influence of environment, the boy for a period prefers his father and spurns as "sissy" any show of affection toward women. With adolescence his interests begin to shift once more toward girls. The things that may block this normal development or stop it at any stage because of one trauma or another—threats as to sexual activity, rejection by one or the other parent—are too many to list and even more difficult to evaluate. Even in clear-cut histories of early seductions, their role in the causation of homosexuality is hard to determine.

However obscure the etiologic trails, we know more about the vicissitudes under which homosexual manifestations take place. The homosexual is not alone in taking only a member of his own sex as object choice. We all have homosexual object choices which indeed most of us satisfy in so called sublimated ways. Our pursuits with pals, our most intimate in-

tellectual and social friendships, our arm-in-arm singing at the piano after a few beers, our sports activities—all have in the broad sense some sort of homosexual connotations. These we value and enjoy without guilt or shame. No one is so masculine as not to expect some friendship or tender affection from a member of his sex. These things stem from our early childhood sexual wishes—sexual in the widest meaning—from the emotional life so intimately connected with our physical beings and the spiritual aspects of love. This point needs emphasis because of too much palaver about spiritual expressions of love as somehow being unconnected with our biological history.

Besides the mild and socially acceptable expressions of sublimated homosexuality, many other manifestations appear. Although not particularly abnormal or peculiar in the course of ordinary masculine activity, they yet indicate how protean are the forms and relics of homosexual wishes. For example, many a man is more potent and has a much more satisfactory heterosexual relationship after "a night out with the boys." Many a man, often without realizing it, feels keener, more intense interest in the woman's sexual experience than in his own. Indeed his partner's frigidity may cause him much frustration in his sexual life not only because he feels he is not proving himself a man but also because she does not let him share in feminine pleasures. Many men secretly envy women's creating and nurturing qualities and activities. Fortunately, the social trend now makes acceptable such masculine envy of women; the tables turn and we hear much less about feminine envy of men. The line is hard to draw between these normal manifestations of homosexuality and near-pathological activities. Surely a patient addicted to prostatic massage satisfies some homosexual needs that may bear scrutiny under a psychological microscope. Likewise a physician who unwittingly plays partner to this game may well scrutinize his role.

Such complex psychological attitudes clearly show that psychologically we are not wholly one sex or the other. Our deeper understanding of homosexuality has also affected our nosological concepts of mental illness. For instance, often homosexuality, as such, harms a person less than does the fear of homosexuality. Many homosexual conflicts that bring a patient to a physician or psychiatrist for the first time have little to do with homosexuality. The patient really fears some dissolution of his psychic apparatus or of his integrity as a person, and he picks on homosexuality as a first sign of dissolution. Many schizophrenic breaks first began with fears of homosexuality; that is, the concern about homosexuality is symptomatic, just as alcoholism is symptomatic of a much more important underlying emotional illness.

TREATMENT

Very little is known about therapy of homosexuality. Just as the extent of homosexuality is greater than commonly believed, so the recoveries from distressing homosexual conflicts are probably more than we think. Doubtless a good many persons through experience, kindness, tenderness and understanding are helped to get over their difficulties in ways we can now only speculate about. Many a homosexual person embarks upon heterosexual experience or even marriage in the attempt to cure himself and sometimes he is successful. Clinicians do not see these successes, but rather the failures of such heroic attempts. Sometimes hormonal treatment is successful. I get the impression in review of such "successes," that psychological, suggestive factors have had more importance than the chemical ones, and that no real cure has resulted.

Psychological treatment does not offer a much brighter picture. Homosexuality as such can hardly be treated because treatment of the underlying emotional disturbance is the essential thing. If homosexuality is touched, all to the good; if not, treatment can often enable the patient to accept his condition with more grace and ease, with less shame and guilt, so that he tends to get into less trouble than before. With some gain in clinical knowledge, satisfactory cures by psychiatric and especially by psychoanalytic treatment have slowly increased, but as yet the number is very small. Treatment is long and most difficult, and the course of a successful treatment very hard to report and explain.

To understand part of the difficulty, take one analogy: It is in general just as hard to change a homosexual's object choice as it would be to change a heterosexual into a homosexual. A case in point is that of a man prominent in public life, who consulted a well known psychoanalyst, saying bluntly: "I'm a homosexual with many compulsions and obsessions. I can't pass a gate without wanting to run my fingers or cane along the pickets. I have to go back ten times to make sure I've locked the door. I have to count to a certain number before starting any undertaking. I feel perfectly comfortable with my homosexuality. I have many agreeable companions who share my views. But my compulsions interfere with my life and I would like treatment for them without touching the homosexuality. Will you treat me under these conditions?"

The analyst replied that because homosexuality is so extremely difficult to cure they could undertake treatment, with the patient's understanding how small the chance for such outcome. The man entered treatment and at the end of two years he was cured of homosexuality. He married happily and had two children. But, alas, all his compulsions and obsessions remained intact and untouched.

The general physician in his role with homosexual patients had best restrict his activities to what may be called minor psychiatry. To practice it, he must form his attitudes from some understanding of medical psychology and not from the statute books. He or anyone who handles these problems must drop his judgmental attitudes and not discuss homosexuality with the patient or his parents as if it were a sin. The physician should allay parental anxiety, especially with patients in childhood or early adolescence, in whom experimental curiosity may play a large role.

If the physician believes that a real problem exists because of a conflict to be resolved, the patient should be referred to a psychiatrist for evaluation and a consideration of means of treatment. If psychiatric help is advised and the patient refuses it, the general physician at best can only counsel him to keep out of trouble—to choose his companions discreetly, not to pick up strangers in public toilets or invite them to his home for homosexual purposes —and inform him about the chances of blackmail or other entrapment and arrest. Because treatment is so difficult, only those with the greatest knowledge, training and experience should attempt it.

At times the patient will refuse even a referral for psychiatric evaluation. He may try arguments, persuasions, even threats. Often he will insist that because he has great confidence in him, the general physician continue the attempts at therapy. This places the physician in a most difficult dilemma. Sometimes he may be strongly tempted to work some magic trial of hormonal treatment or to delve into the patient's psychic apparatus. The physician would do best to withstand the temptation to an involvement that may indeed carry him away into dark seas of interpersonal relationships where even the most gifted mariners may lose their way.

It is encouraging to see that a favorite treatment of a generation ago has waned—the attempt at cure by arranging a sexual alliance with a prostitute or a knowledgeable substitute, a device not infrequently used even by some psychiatrists. Such attempts to teach the homosexual the facts of life or to make a man of him have precipitated more than one schizophrenic break.

The general physician, often the first to be consulted by the homosexual, must be prepared to deal at the start with cases of great psychological complexity. Homosexuals are liable to be hostile or paranoid and to present problems bordering on addiction or psychosis. Again, however offensive the behavior, shaming or deriding or reviling has no more place in the treatment of such persons than in the treatment of any other medical condition.

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